Health & Wellness Services

Quest Diagnostics™

PHYSICIAN FAX PROGRAM INSTRUCTIONS

1. Schedule an appointment with your personal physician to receive your annual preventative screening examination.
2. Complete Section 1 of the enclosed Physician Fax form.
3. Take this Physician Fax form to your physical examination and have your physician complete Section 2 of the form. A licensed Medical Professional's signature is required.
4. Make a copy of the Physician Fax form for your records.
5. Once a Physician Fax form is completed, the form should be faxed to Quest Diagnostics at: **248-416-1197** or email to BSCAfaxes@summithealth.com.
6. Do not fax or email medical claims, other information or documents with this form. Any extra documents you fax or email cannot be returned and will be destroyed.
7. Whether received by fax or email, all first submission forms must be received by the date determined by employer in order to receive credit for completion of the Physician Fax Screening program.

If you have questions contact Quest Diagnostics toll free at 1-888-240-0962

Health & Wellness Services

Quest Diagnostics

County of San Bernardino
E0245384
Health Care Provider Biometric Screening Form

INSTRUCTIONS:

- PARTICIPANT - complete section 1
- HEALTH CARE PROVIDER - complete section 2

Please fax completed form to Quest Diagnostics Health & Wellness Services at **(248) 416-1197 or email to BSCAfaxes@summithealth.com**

SECTION 1 - PARTICIPANT INFORMATION - Print clearly. If the form is illegible it will not be processed.

Participant's Date of Birth (MM/DD/YYYY) / / Gender M F

Participant's First Name MI Participant's Last Name

Address Unit/Apt

City State Zip Code

Email Address

Phone Number - -

Are you: Employee Spouse Dependent

Please read the following disclosure statement. I understand that my health screening data will be released to health plans associated with my company for the purpose of follow-up health education and disease management counseling (if eligible). My individually identifiable health information will not be shared with my Employer; however my Employer may be advised of the fact of my participation in this health screening for purposes of qualification for incentives offered by my Employer. In addition, if my Employer offers incentives related to "pass/fail" test results, my "pass/fail" test results may be disclosed to my Employer for those incentive purposes. My health screening test results may be disclosed to vendors engaged by my Employer or Employer-sponsored group health plan for purposes of determining my eligibility for an incentive related to this health screening, for health management and/or disease management services including data aggregation for program improvement purposes, and/or for purposes of population of my Personal Health Record available online and/or my Health Risk Assessment (HRA). The importance of safeguarding individually identifiable health information is recognized and all organizations involved in this Biometric Health Screening are obligated to take reasonable steps to protect such information from unauthorized access or use.

Participant's Signature: _____ Date: (Month) (Day) (Year)

PATIENTS: Biometric Screening must be completed by (04/30/2017) to receive completion credit or incentive (if applicable). This form must also be completed in its entirety, accurately and legible in order to be deemed complete.

SECTION 2 - BODY MEASUREMENTS / BIOMETRICS RESULTS - For physician or office staff use only below this line.

FOR HEALTH CARE PROVIDER: *County of San Bernardino* is offering a voluntary wellness program to encourage participants to understand their health risk

Blood Panel

Total Cholesterol: HDL: TC/HDL Ratio:

Triglycerides: LDL: Glucose:

Fasting Status (Check one)

Fasting

Non-Fasting

Blood Pressure

Systolic

Diastolic

Body Composition

Height ft in BMI

Weight lbs

Pulse

Tobacco Use

Yes

No

For Females Only:

Currently Pregnant or Pregnant within the last 12 months

Yes No

I certify the listed biometric values are correct

Facility Name: _____

Phone Number: _____ Date of Service/Test: _____

Health Care Provider's Name: _____

Physician's Signature: _____ Date: _____

Please fax completed form to Quest Diagnostics Health & Wellness Services at (248) 416-1197 or email to BSCAfaxes@summithealth.com by Deadline 4/30/2017

Date Faxed: _____

NOTICE: Any form submitted incomplete, inaccurate or not legible will be deemed invalid